Local Managing Entity Utilization Management Information Session

November 25, 2008
2:00 pm – 4:00 pm

Cameron Village Public Library
Raleigh, North Carolina

Notices were mailed to all Local Managing Entities (LMEs) inviting these potential Utilization Management (UM) vendors to an Information Session on November 25, 2008 held in the Cameron Village Public Library starting at 2:00. Representatives from the following organizations were present:

DHHS - Division of Medical Assistance (DMA), Division of Mental Health (DMH), Division of Aging and Division of Information Resource Management (DIRM).

LMEs - Western Highlands, Pathways, Mecklenburg, Crossroads, Durham, Wake, Eastpointe, ECBH, Southeastern Center, Onslow-Carteret, and OPC.

Centers for Medicare and Medicaid Services (CMS)

Private Agencies – ValueOptions (VO), EDS, Strategic Behavioral Health, ARC

An attendance sheet is attached.

Tara Larson, Acting Director of DMA, facilitated the meeting. Introductory remarks focused on explaining the overall purpose and scope of the requirements for Utilization Management. In North Carolina, Utilization Review has been longstanding for numerous behavioral health services starting with inpatient services and later expanding to include outpatient and child residential treatment. With the implementation of the Enhanced Services in March 2006, it was necessary to expand this function to include all Behavioral Health services. The requirements for this function are more than providing prior approval for services – it represents the overall management of service delivery for Medicaid recipients but does not control the size of the network. The effectiveness of the vendors supplying these services should be evidenced in the aggregate patterns of access and treatment.

ValueOptions has played an important role in the development of the current standards for UM. However, these are changing as NC improves its system of care. Expectations for all vendors – both VO and the LMEs – will be the same and are reflected in the "UM Requirements and Procedures" document.

It is mandatory that UM processes are standardized for all Medicaid recipients among all vendors. Working together will be necessary to assure not only a smooth transition of UM responsibilities for selected recipients, but also to continue to apply clinical protocols that implement DMA service criteria and best practice standards. All Medicaid recipients must be provided equal treatment and equal access to treatment regardless of their county of eligibility.

A confounding issue will be the nature of the payments to LMEs. LMEs already receive Medicaid funding for system management functions. VO receives a fee based upon the quantity and type of transactions. As the two Medicaid funding options are implemented, the state must ensure that there is no duplication of Medicaid funding for staff activities. Since the LME systems payments can not be modified without CMS approval, a lower rate for transactions may be applied to LMEs if duplication is noted.

The relationship between the selected UM vendors and DMA will be quite different from what has occurred historically. Previously, LMEs have been partners with DMA under the oversight of DMH. As a UM vendor, the LME will be treated as a contractor/vendor, a business relationship. DMA is the contract manager and will monitor performance to assure compliance with contract specifications. While we will seek to work together, DMA can not diffuse expectations based upon prior relationships or shared interests.

Any interested LME is encouraged to submit the application if they feel they meet the requirements outlined. This will assure the very best performance in this endeavor. The target of covering a minimum of 30% of the state's population by LME UM functions must be met by July 1, 2009; if the responses exceed this requirement, then further direction from DHHS will be sought. Once the selections are made, a 3 year contract will be executed with the option for an additional 2 years, renewed annually.

Once the LMEs are selected, the LMEs, DMA, DMH and VO will work together implementing the work schedule required to ensure operations by July 1, 2009.

LME UM Proposal
Questions and Answers

1. Can LMEs receive the history of VO activity for our consumers related to:
    - Initial Reviews per service
    - Concurrent Reviews per service
    - Post Discharge Reviews per service
    - Quality Assurance Reviews
    - Reconsideration Hearings
    - Special Team Reviews
    - CAP Plan of Care Reviews (annual, mid-year and off cycle)
    - EPSDT Reviews
    - Hospital and PRTF post payment reviews

    These figures at the individual LME level seem essential to determining feasibility based on anticipated staff cost versus projected activity revenues.

    - **The numbers were sent as hard copy in the package mailed to LMEs. As requested in the meeting, data from July 1 through November 30, 2008 has been requested. Once received, the information will be uploaded to the website.**

2. LMEs cannot act as a Medicaid recipient's legal guardian. Would it be permissible to swap guardianship consumers with another LME? In this plan, Crossroads would perform the guardianship functions for the Medicaid Wards of another LME and another LME would perform the guardianship functions for the Crossroads LME?

   - **LME's shall not serve as a guardian for any Medicaid recipient for whom the LME authorizes services to avoid a conflict of interest. LME's should work with the local Clerk of Court to manage the transfer of guardianship of recipients from the LME if the LME will be assuming utilization management for those recipients.**

     Per G.S. 35A, LME Directors or Assistant Directors may be appointed as guardian as a disinterested public agent. "A disinterested public agent may not be appointed as the guardian of an incapacitated adult unless there has been a diligent effort to find a qualified, willing, able, suitable, and appropriate individual or corporation to serve as the ward's guardian and the Clerk determines that appointing a disinterested public agent, rather than an individual or corporation, as guardian is in the ward's best interest. G.S. 35A-1214

     As discussed, some LMEs have "contracted" the service out. In essence, the guardianship could be assigned to the contracted agency, the court naming the agency as the guardian. A contract may be needed if there is a payment for acting as guardian. LMEs may work among each other to transfer guardianship to another LME. Options should be explored in accordance to guardianship policy and rules.

     Regardless, for the purpose of UR, the LME conducting UR shall not be the guardian.

3. Regarding Legal Actions - Are appeals to the DHHS Hearing Panel, Hearing Officers, or the Office of Administrative Hearings (OAH) considered legal actions for the purposes of this application?

   - **If you are referring to Section III.D. Legal Actions, page 5, appeals are not considered legal actions for purposes of this application process. The intent is to identify pending or closed legal activities that could/do have financial liability for the LME, thus affecting their financial viability.**

4. For the full time contract manager with a clinical background - Is DMA referring to a contract manager in relation to the DMA contract for UM functions? As opposed to a contract manager for the many providers serving consumers under a contract with the LME?

   - **DMA is referring to a contract manager in relation to the DMA contract. This would be a person that has experience and skills with managing contracts and would serve as the single point of contact with DMA. This is not necessarily the "contract" manager that oversees contracts in the LME and handles the actual administrative activities of processing contracts, although those functions are necessary. The intent is to have a single point of contact that administers/oversees the process and will serve as the person**

the DMA works with on day to day issues. For example, DMA considers Will Woodell, VO North Carolina's Manager as the Contract Manager.

5. In order to better understand the current vendor's scope of operation, as related to transition planning and service integration, Mecklenburg would like a copy of the current contract between DMA and ValueOptions (VO).

   - **Transition planning for this project has not taken place yet. LMEs selected will be included in this planning process. Detailed transition planning is part of the process that will be jointly designed by DMA, DMH, VO and the selected LMEs. The transition requirements referenced in the requirements document is intended to have the LME identify what needs to happen from their perspective moving their current operations to meet the requirements and for the providers and consumers in the catchment area**

     The VO contract is undergoing amendment to bring requirements in line with all the changes given to VO verbally and written, since the previous amendment. The LME's will not be asked to provide any operations or meet performance measures not also required of VO at the time of implementation.

6. On page 62, one of the performance measures related to treatment patterns describes a methodology of mapping diagnosis and previous treatment patterns. How has this been operationalized? What is the current vendor's experience? What improvements have resulted as a result of the implementation of this outcome measure?

   - **It is up to each LME to determine how the LME will operationalize the requirements provided in the LME UM package. This performance measure relates to the LME's use of identified best practice standards and established diagnosis based treatment guidelines to guide clinical decision making. An LME's decisions regarding type and amount of services authorized and recommendations by an LME for more appropriate services due to an individual's diagnosis and history, must be informed by and take into consideration established practice guidelines. These practice guidelines and parameters include generally accepted practices. They are not intended exclusively to dictate care or exclude other treatment approaches or modalities. It is recognized that clinical care decisions must be made by the clinical care reviewer in light of all of the clinical evidence presented by the provider and the diagnostic and treatment options available. However, the LME's approval of services will be reviewed against generally accepted standards and significant variances from accepted standards must be well justified. This function is one means to determine consistency across the state, service gaps, and approval/denial patterns for providers and for recipients.**

     Self-monitoring of this standard should occur through analyzing referral patterns, services being authorized per diagnosis code, patterns of authorizations to provider types, etc. Patterns identified may require performance improvement strategies. In recognition of the nature of this performance measure, the language will be changed to re-classify this measure as a quality indicator and the financial deductions will not apply.

Examples of established practice guidelines that are available, include those published by the American Psychiatric Association that can be found at www.psych.org/MainMenu/**Psychiatric**Practice/PracticeGuidelines_1.aspx **and those published by the American Association of Child and Adolescent Psychiatry that may be found under Practice Parameters at https://www.aacap.org/cs/root/publication_store. The submitted proposal should include a list of resources that will be used in making medical necessity decisions. Also, it is anticipated that the DMA may move toward standardized clinical protocols in the future to assure consistency between UM vendors.**

7. In reference to the other performance measures, what is the performance of the current vendor? What is the history of reconciliation's as a result of these measures?

   - **VOs performance is under constant monitoring by the Division. Below expected performance has resulted in required performance improvement plans. Currently the VO contract does not contain monetary penalties. The VO contract is undergoing amendment to bring requirements in line with the ones in this LME requirements document that will be effective 7/1/09. The LME's will not be asked to provide any operations or meet performance measures not also required of VO at the time of implementation. DMA will implement more formal monitoring processes over time. VO has been under a monetary withholding due to issues with invoicing. Initial withhold penalty was 30% and has been reduced over time to currently 3%**

8. Item # 9 on page 2, Part A: Minimum Requirements for Participation, states that the Information System must be accessible remotely by DMA. How do you define remote access? What has the experience of the current vendor been with this function?

   - **Remote access is the ability to access the LME IT UR system via the internet. This is one means that DMA uses to conduct look behinds of the data being submitted in reports, to monitor actual clinical care systems described in the requirements and to ensure that day to day operations happen in accordance to the contract requirements. DMA will work with the LMEs to create logistics and procedures that safeguard the information provided. DMA limits the number of staff from DMA who can conduct these functions.**

9. In reference to the requirement for a full time medical director, how does the anticipated increase in volume from 1-30% of the Medicaid population equate to the necessity for a full time MD as of May 15th?

   - **The requirement is that the LMEs have a full time Medical Director regardless of population served. This requirement may be met through employment or a full time contractor.**

10. In reference to the requirement for a fulltime Contract Manager, how is this staffing requirement met by the current vendor?

    - **The current vendor has a full time Contract Manager.**

11. In Part B #5, the proposal speaks of a Provider Call Center. How is this operationalized with the current vendor? Additionally, there are conflicting performance requirements documented in Provider Assistance - is it 2 business hours or 2 business days?

    - **It is up to each LME to determine how they will meet this requirement. The current vendor has a Provider Call Center. The LMEs do not have to operationalize this in the same manner as the current vendor. Calls must be returned within 2 business hours. This will be corrected in the next release of the policy requirements.**

12. In section F: Receipt of Service Authorization Requests on page 18 there is a statement that the LME must be able to receive authorization requests via email. How does this process work? What is the current volume of email requests to the current vendor? How is this operationalized in compliance with HIPPA regulations?

    - **It is up to each LME how it will operationalize this requirement. The current volume of the current vendor does not affect this requirement. Each LME must have this capability. The process the LME puts in place must be HIPAA compliant. Data provided to the LMEs illustrates the volume of decisions reached. That number is an underestimate of overall volume to requests since some will be returned for administrative reasons, some for additional information, etc. The LME must have the capacity to handle the volume and process without delay, and in accordance to the requirements.**

13. In section B #2, what methodology is applied in the determination of an erroneous decision? How is this being operationalized with the current vendor?

    - **According to the Requirements document (Section XIV.B. 2 and 3) the methodology for determining erroneous decisions is as follows.**

> **2.** ***Erroneous Decisions***
> *Erroneous decisions are defined as authorizations and denials that violate an officially promulgated federal or state regulation, policy or directive. In cases of erroneous decisions, the LME shall reimburse DMA for the total cost to DMA of the service(s) provided in error.*
>
> ***3.*** ***Record Review***
> *On a quarterly basis, a random sample of cases will be selected by DMA from the LME's database and the LME shall send DMA copies of all documentation on the sample cases.*
>
> *This review may include but is not limited to the following:*
> - *If the LME approves/authorizes an admission/service based on an incorrect/invalid CON, the LME shall reimburse DMA for the payments made to the provider*
> - *If the LME approves/authorizes a service based on incomplete information, i.e., lack of service orders or unsigned PCP, the LME shall reimburse DMA the total cost to DMA of the service(s) provided in error:*

- *In cases of erroneous decisions, the LME shall reimburse DMA the total cost to DMA of the service(s) provided in error.*
- *DMA reserves the right to sample as many services as it deems necessary to assure quality.*

To date, DMA has only applied the performance standards for CONs as part of post payment reviews. Typically, when erroneous decisions are identified, a performance improvement plan is initiated and monitored to determine corrections. If this first intervention is found unsuccessful, then penalties would be applied.

DMA is looking for patterns of errors, gross negligence and failure to implement and follow agreed upon medical necessity criteria or other specific rules. As discussed in the meeting, CAP-MR/DD services are not allowed in schools. As part of a review, if the authorization was approved and the documentation clearly pointed to school as the location of service, then the LME would be accountable for payments made. Under what conditions of recoupment and level of threshold will be written in the contract between the PA vendor and DMA

14. Will an integrated (single county) financial audit meet the requirements for balance sheets and other financial statements?

    - **Yes as long as it meets the requirements outlined in III.C.2.**

15. Economies of scale and operational efficiencies would seem to indicate that there are financial incentives involved in an integration of staff performing Utilization Management for both IPRS and Medicaid recipients. Your request seems to prohibit this. What is your rationale for this segregation of staff?

    - **It is permissible to share FTEs between DMA UM functions and State funded functions if the work load requirements are met and appropriate cost allocations are made. In terms of work requirements, this is permissible. However, there is a financial issue with doing this that must be resolved. DMA must ensure that Title XIX funds are *not* used to pay for state funded authorization activities and services. This is strictly prohibited. Currently, LMEs are already funded by Medicaid for a portion of their system management fee; to add a transaction fee to this payment has potential of duplicate payment for the same functions. Further analysis and identification of potential solutions will be forthcoming.**

      LMEs must know that if this occurs, reduction in one funding activity will happen. The LME system management fee consists of certain functions and staffing. The UR data and cost structure that was distributed is an inclusive rate that captures the requirements of the UR/UM as outlined in the document. Changing or allocating staff over the two funding streams means that the rates are no longer in line and there could be duplication of payment. LMEs should consider this possibility and impact when making their decision.

      Changes in the systems management fee structure will require CMS approval.

16. On the cost analysis schedule, please define "provider changes; provider changes – single service and provider change/single service?"

- **The separate rate for provider changes applies to authorizations for CAP-MR/DD services, primarily DME, CAP supplies and Home Modifications. The information was recorded in the VO system under different processing codes. All three lines are provider changes.**

17. The LME cost per service analysis has no date span. Are the costs based on '06 – '07 data?

    - **July 1, 2007 through June 30, 2008. A request is being made to obtain more current data for your review, covering July 1, 2008 – November 30, 2008.**

18. There are prohibitions against the subcontracting for any UM functions. Does this apply to contracting for the services of physician advisors (e.g. use of Prest for PA services involving specialty areas like child/substance abuse)?

    - **Per IV. G. you may not subcontract with an entity such as Prest to perform UM functions. However, you may contract for an individual's services.**

19. There is considerable cost involved in up-fitting and reorganizing the current LME operation in order to accommodate the inclusion of the Medicaid business. As such, what provisions and/or exceptions are in place to mitigate the financial outlay initially required of the LME (e.g. phasing in of additional UM staff, phasing in of F/T psychiatrist, etc)?

    - **There are no provisions or exceptions to the LME meeting the requirements in the proposal package. See Section III.C.1. The LME must have the financial resources to meet all of the requirements for the provision of Medicaid utilization management and utilization review. No Medicaid start up funding is available. There are no provisions in place to mitigate the financial outlay such as phasing in required staff.**

      DMA does not pay vendors for start up costs. When pricing is submitted for various services by vendors, typically rates factor this plus any other unforeseen costs. Since, rates for LMEs are not negotiated and are the same as currently being paid, this is not an option. No start up funding was provided to VO.

20. When getting QIO-like certification does DMA require Physician Access or Physician Sponsored QIO-like certification? Due to the timeframe involved in this contract implementation will there be any extension to the timeframe to obtain QIO-like status?

    UM providers must have QIO like certification in order for Medicaid to earn maximum federal match dollars for these activities and would be designated as a Physician Access organization. There must be evidence that LME's have submitted all documentation for this certification by the time of application. Attached is the handout distributed at the meeting.

21. On the fee schedule, what does the "reconsideration process" fee cover?

- **$232.92 is provided to cover staff time in defending adverse decisions. Preparation time is not separately billed. This amount covers the time in the hearing. All travel and preparation expenses are non-billable to DMA.**

22. It is common practice to have a cure period for things found to be out of compliance prior to fines or with holding of payment, will this contract include a cure period?

    - **Yes, it will include an initial 3 month cure process.**

23. The document 17.1.F bullet 5 suggests that all things shall be password protected. Is that really just specific to PHI?

    - **This requirement is broader than just pass word protecting PHI material. All of your applications and transactions must be pass word protected or encrypted. Your entire system must be secure. This includes all security requirements in accordance to state policy.**

24. Section 4.4 requires a full time QI manager but the checklist does not include this position, is the position required?

    - **Section 4.4 states "A full-time employee whose duties include being the Quality Improvements Manager". The LME needs to identify the position and person who is, and who will be held, accountable for the Quality Improvement activities for Medicaid UM/UR functions.**

25. Can the LME, funded by DMH and DMA contracts; use .5 of an employee for DMH UM in SA and .5 of the same employee for DMA UM contract, as long as in total FTEs the LME has enough to manage the work load requirements when the volume doesn't support an FTE?

    - **We understand this question to be asking is it permissible to share FTEs between DMA UM functions and State funded functions if the work load requirements are met. In terms of work requirements, this is permissible. In addition, you may use a combination between contractors and employees to meet the needed FTEs per population as long as you have ready access to these individuals when needed. However, as noted above, there is a financial issue with doing this that must be followed and financial impact considered.**

26. Given the LME has provider relations functions and the DMA contract has provider relations functions, can the staff who perform this function all work in the same call center or does this contract expect the LME to set up one call center for the DMA contract and another call center for the DMH contract or is the design up to the LME as long as the LME is able to comply with requirements in the contract?

    - **Yes, but again there will be financial issues with this that must be resolved to assure that Medicaid does not pay double for administration of Medicaid services. Currently Medicaid is paying for this function in the LME and this function is also included in the LME UM transaction fee. There can't be duplication of payments for the same function**

27. Given the LME funded by DMH already has UM, PR, and CS staff who perform various clinical and clerical functions and in some LMEs many of these functions are interdependent and cross functional, could an LME simply add more staff to existing infrastructure to accommodate the new or different aspects of this contract with DMA or is it the expectation of DMA that an LME will truly house a DMA "side" separate from the DMH "side"? If there is a separate expectation with only the CEO in common has DHHS considered the cost savings of allowing a more integrated process with LMEs vs. this separation of the same functional components?

    - **These may be integrated if all staff qualifications and timelines for DMA are met. If there are differences in staffing qualifications or other requirements, Medicaid's requirements prevail. There will be financial issues with this arrangement.**

28. Given the LME already has an IT or MIS Director, does this contract expect an additional person be hired to accommodate the DMA contract or can the LME simply scale the department based on the volume, which is more economical?

    - **It permissible for one IT/MIS Director to manage DMA UM functions and State funded functions if the work load requirements are met. In terms of work requirements, this is permissible. However, there will be financial issues with this arrangement.**

29. The appeals/hearing procedure section. On page 60 it says we are notified when a request of hearing has been received and just before that says we are to keep copies of the Recipient Request Form. On page 59 however it says the form is sent to DHHS and OAH. There is no mention of the LME. Who sends this form to the LME?

    - **This is new legislated requirement and access to all of the needed hearing information is going through a centralized IT client appeals clearinghouse. The LME, OAH, all DMA PA vendors, DMA staff utilize this process for meeting the legislation which includes posting decisions, being notified of mediations, hearings, and final decisions. The LME will get an email that directs them to check the PCG web-site where it will be posted. This will be the initiative to enter MOS, develop hearing summaries, prepare for mediation or a formal hearing, etc. The selected LMEs will be trained in the process.**

      The LME should consider the volume of the decisions, not just the appeals and make appropriate staff decisions for meetings timelines and also for the IT infrastructure.

30. There are only two choices on the response form. If an LME is interested to doing Medicaid UR but not at this time due to knowing they do not yet meet the readiness criteria, should the LME mark "yes" but note this? Does this mean that, even if not ready, DMA is expecting a complete proposal to be submitted at this time? Conversely, if an LME checks "no", does this preclude that LME from further consideration at a later point during 2009 or early 2010?

    - **The LME should mark 'no' it is not interested in performing UM functions. We are interpreting all 'yes' responses to indicate the LME will be operational by July 1, 2009.**

This "NO" decision will not preclude a LME from UR/UM functions in the next round or in the future.

31. Section VII.J.1, reference to use of eligibility file for processing of authorization and claim processing. What claims processing are you referring to here?

    - **This is a mistake and will be corrected with the next issuance. The file is not used by LMEs for claim processing.**

32. Section VII. J. 2 reference to resolving duplicate MIDs during cross referencing. What does this process entail?

    - **The LME must send an e-mail to DMA according to the LME Requirements document in Section VII.J.2. This is all the LME is required to do.**

33. Section IX. A, confirm that paper mailings are indeed expected, and how/when they are to be sent. This seems to be part IS/IT (letter generation as pdfs?), and support staff (letter distribution). What is meant by "trackable mail"…return receipt?

    - **Paper mailings are required and must be mailed within one business day of the decision. Examples of track able mail are return receipt, certified, UPS, FedEx, etc. It is important for the UM vendor to be able to clearly demonstrate that the notice was sent, where it was sent and on which specific dates. This information is used in hearings and for monitoring of the vendor to contract requirements.**

34. LME not serve as legal guardian -- Contracted out, however, the law states that LMEs are still "legally responsible" - applies to all LMEs? Will there be funding for contracted guardianship? If the guardianship is contracted out - is the LME still considered "guardian" under DMA - the state statute (see above) seems to imply the LME is "ultimately" responsible?

    - **LME's shall not serve as a guardian for any Medicaid recipient for whom the LME authorizes services to avoid a conflict of interest. See question #2 above.**

35. Referrals to any entity in which LME is member or investor -- Is this the LME referring to itself (if still provides services) or 2nd employment by staff at LMEs?

    - **An LME who provides UM functions shall not provide services itself. It must be divested of all service delivery, with the exception of pass through billing that is being conducted for non-enrolled providers of direct service. The LME may not employ nor contract a person as a reviewer who could potentially be in a position of authorizing services for the person's secondary employer. This includes consultants.**

      Since the LME also provides referral services as a non-UR/UM function, referral patterns may not be only to preferred providers or to LME spin-offs. Authorizations/denial patterns will be reviewed to ensure no preferential treatment.

36. Automated Info Mgt System capable of performing all activity, interfacing, reporting req. of UM - accessible remotely by DMA -- What does remote accessibility mean? E.g., similar login like providers do?

    - **See question #8 above.**

37. Abide by all requirements in application & any subsequent changes to the document -- Does this assume subsequent funding attached to additional requirements?

    - **If additional services are added that will require utilization review, DMA would set a fee to cover the new authorizations. If new administrative requirements are imposed that are not included in the contracted functions, rate negotiations may be needed. This will be dependent on the scope of needed changes and funding availability for this purpose. Authorization frequencies, letter changes will not result in additional funding. IT and programming requirements needed to facilitate the changes will not receive additional reimbursement.**

38. One FTE MD - NC MD license - board certified in psychiatry -- What is the state's rational for this not being divided among just 2 MDs - nothing in state/Fed rules says this cannot be more than 1 person? What happens when MD is gone? Recruiting when 1 resigns?

    - **The rationale is having a single point of accountability and consistency of clinical decision making. The LME will be responsible for arranging to meet its workload requirements during any transition period or absence. There are no exceptions to not having the functions covered.**

39. What is the minimal ratio of licensed clinicians to QPs to perform UM? Is there a role for QPs outside of the DD/MR area?

    - **Staffing levels must be adequate to meet workload and timeliness requirements. There are no minimum ratios established. Unlicensed QPs may only authorize services for DD/MR clientele under the supervision of a Licensed Professional. Unlicensed QPs may function in other administrative roles or perform non clinical duties for which they meet the requirements as long as this does not create any conflict of interest for the individual or the LME.**

40. 4.4.1 Access to psychiatrist - NC MD license board certified or board eligible in child psychiatry and 4.4.2. Access to a physician - NC MD and board certified or board eligible in ASAM -- Can 4.4.1 & 4.4.2 be the same person? IV.A Page 7

    - **They may be the same person as long as they meet all requirements for each position**. **The LME must also consider the various functions that must be met by a MD and the timelines associated with such**.

41. 4.4.8 Staff available that have special expertise with children and the elderly + received training in cultural competency specific to key ethnic groups --What is meant by "practitioner"? Only bullet where this term is used?

    - **We are unable to find the word 'practitioner' on page 7 as referenced in 4.4.8. It does appear on the following page in reference to nurse practitioner as someone who is qualified as an advanced practice psychiatric nurse practitioner. The intent is to have qualified licensed staff with specific expertise.**

42. 4.8 Process for verifying staff credentials and report credentials to DMA as specified --What is meant by "individual clinical staff background checks"? - criminal? education? And with a "report" - do actual credentials and proof need to be attached or is attestation alone sufficient?

    - **Individual clinical staff background checks refer to submission of names of clinical staff to both state and federal authorities to determine if they have criminal records that would impact their suitability for working for state or federally funded projects. Proof of background checks, resumes and credentials, such as copies of diplomas and licenses do not need to be submitted with the staffing report, but these documents must be maintained in the credential files and will be subject to contract monitoring.**

    - **In addition, the proposal submission should include a list of staff to fill proposed key positions if currently employed. This should include the following: CFO, COO, Contract Manager, QI Director, IT Director, Provider Relations, Medical Director and UM Manager (identify roles may be shared by the same individuals). Please include Curriculum Vitas and background checks for these individuals**

43. 5.1 Provider call center sufficiently staffed to meet performance requirements -- 1st callback (p.11) - within 2 hours - for TAKING provider complaints 2nd (p.64) - getting back to providers in 2 business days - right?

    - **This is a mistake and will be corrected in the next issuance. It is 2 business hours not days.**

44. 7.4 Activities surrounding service auth requests & review shall be documented -- When will the new SAR to be used across the state be adopted?

    - **If this question is referring to the Service Request Form, this document is anticipated to be completed by February 1, 2009. It will be adopted by the state for use by LMEs. VO will continue to use its own propriety forms.**

45. 7.5 Ability to receive/process auth requests via surface mail, telephone & secure e-transmissions to include e-mail, web-based & FAX -- For approvals, why can't providers be notified only electronically and have providers notify consumers?

    - **The LME is directly responsible for the decision and the mandated notification of the recipient of the outcome of the decision. This responsibility for notification may not be**

delegated. Federal law requires that Medicaid will notify the recipient of action and the PA vendors are the agents conducting the function on behalf of DMA. Providers are not the Medicaid agent.

46. 7.6 Initial Reviews (Initial Auths) - performed within designated timeframe -- What does DMA require as proof?

    - **LMEs will be sending daily files to the Fiscal Agent (EDS) which will contain information needed to monitor this.**

47. 7.7 Concurrent Review (Reauths) must be performed within designated timeframe -- What does DMA require as proof?

    - **Same answer as #46 above.**

48. 8.7 Quality Assurance Reviews -- p. 24 - Do you want a;; Level 1,2 & 3 incidents reported to LME reported to DMA? Currently do not get discreet data on L1 incidents.

    - **The incident reports for UM are not identical to Client Incident Reporting. The scope of this reporting may also entail such issues as practitioner licensing, provider issues, ethical treatment practices, HIPAA breaches, etc. This process will be further defined in conjunction with the selected LMEs to reflect their unique position in managing client incidents.**

      As discussed in the meeting, the LMEs already have an incident reporting requirement. Since VO or other DMA vendors didn't already have the requirement as LMEs, a process had to be put in place that would require the vendor to notify DMA of incidents so that Medicaid could address health, safety and quality concerns. DMA will relook at this requirement. For purposes of the application, the LME should outline how the reporting process found in the UR review process will be reported to the other section of the LME responsible for investigating complaints and impacting endorsement.

49. 12.1 Filing and the hearing process -- Are there any prohibitions against informal resolutions before information is given about appeals?

    - **No, informal resolutions are permissible.**

50. 14.1 Identify how these will be met -- p. 61 A. Objectives - Is this QM Plan within UM or the entire LME? P.62 #2 Is VO doing this now - e.g., error made on Inpatient Hospitalization eligibility and person stays for 6 months - reimburse total stay (approx $126,000) to DMA? Please provide examples of "Erroneous Decisions". Later, is there an appeals process for this - e.g., look in SIPS (aka CICS) and it says "eligible", find out later, SIPS (aka CICS) is wrong, to whom does the LME appeal?

- **For the purposes of this application, the QM must be specific to the Medicaid UM/UR functions, however, this plan may be a distinct part of the LME's over all plan. Please see #13 above.**

51. In the cover letter, it is stated: "these UM services would be for Medicaid recipients receiving behavioral health services in the LMEs catchment area." Question: is the "host" LME responsible or the "home" LME responsible for authorization activity?

    - **UM services are for Medicaid recipients whose eligibility is based in the county(s) encompassed in the LME geographic area. All authorizations will be for individuals whose eligibility originates from the LME regardless of the location for service delivery. Authorization letters will be sent throughout the state to the serving provider and associated LME, as applicable.**

52. Attachment U specifies the incident code table which really doesn't match the current DMH language. Clarity?

    - **These are the codes currently being used by DMA and VO. See question 48 above.**

53. Part A Item 5 – Would this include actions that have been to OAH for LME's who have withdrawn provider endorsement as well as anything that may have gone through other court actions?

    - **See question 3 above.**

54. Part A Item 8 – If a County is "self – insured" would there still be an expectation that the LME purchase professional liability insurance?

    - **If a LME is part of a self-insured county system, they would be required to submit a certificate from the county indicating that the Medicaid UM function would be fiscally covered in a separate reserve or as an identified fund within the county budget.**

55. How will the proposals be evaluated? Will there be a rating scale or some other tool?

    - **The proposal evaluation criteria were issued with the proposal package.**

56. According to the LME UM Requirements and Procedures, LME Requirements for Participation, Conflict of Interest, page 7, Eastpointe, ***"must not authorize services to be provided by any person who is also employed by the LME*.** The LME must not show favoritism to any provider and must avoid biased referral patterns." 42CFR438.58 (attached), which is the Public Health law applying to Medicaid managed care State responsibilities, seems to apply to the State rather than to the MCO/LME. However, 43CFR438.214 (attached) states the MCO (LME) "must comply with any additional requirements established by the State" when selecting providers.

    Will the state clarify the statement on page 7: *Does this refer to employees of the LME who are in private practice only, or are employees of the LME who work as contractors for a provider agency included in this statement as well?*

- **See question 35 above. This applies to employees in private practice and those working for a provider agency.**

57. According to the LME UM Requirements and Procedures, Staffing Requirements, page 10, Eastpointe ***"must not subcontract with any entity to provide the utilization management functions*** outlined in the document." Can the after-hours STR function be subcontracted to a government entity?

    - **STR is not a component of Utilization Management. If STR staff are also making authorization decisions, they are subject to the standards identified in the UM requirements which prohibits subcontracting to another agency. See questions 25 & 26 above.**

58. Page 2 of 7, number 12 - The LME agrees to abide by all requirements contained in the requirements document and any subsequent changes to the document. Can this be Reframed to state LME will be notified of proposed changes to document and inform DMA of its ability to meet the changes, additionally will provide DMA with timelines necessary to meet requirements.

    - **DMA is committed to working closely with the selected LMEs to assure a smooth transition on behalf of clients. Some changes may be predicated by federal requirements where there are strict timeframes for implementation; others may offer more latitude for implementation. We will negotiate timeframes as much as possible depending on the source for the requested changes.**

59. Page 4 of 74.4.8 Staff must be available that have special expertise with children and the elderly and have received training in cultural competency specific to key ethnic groups. Specifically what needs to be done to meet this requirement?

    - **It is up to each LME to determine how they will meet this requirement. There are many ways to meet this requirement and need to be itemized in the submitted proposal. Examples of ways to meet this standard are staff training, staff credentialing, tracking authorization patterns, etc.**

60. Page 4 of 7, 7.5 The ability to receive and process authorization requests via surface mail, telephone, and secure electronic submissions to include email, web-based and fax. We would encourage all requests to be made through the electronic web-based system, however we have the capacity to receive requests through the before mentioned methods. We are concerned that asking providers to send necessary information through e-mail could open up lots of HIPAA violations if not submitted securely by the provider. Can the LME specify a preferred method of submission?

    - **The LME may request providers use a preferred method of communication while still maintaining all options for these submissions but may NOT make it mandatory. The LME must respond within the required timeframes regardless of the means of transmission.**

61. On page 9 of the document staff training is cited. What would constitute training for DUE PROCESS and what credentials are required to provide this training?

    - **It is up to each LME to determine how they will meet this requirement. There are many ways to do so and they should be itemized in the submitted proposal. Monitoring by DMA will consist of review of materials, review of documentation to show training occurred, frequency of training and outcome of staff performance to see if effective.**

62. What will DMA consider as meeting a specialty or adequate experience in co-occurring disorder, child and geriatric for purposes of utilization review of Medicaid by Care Managers?

    - **There are no set requirements for this type of credentialing, although guidance can be gleamed from National Accreditation, Professional Licensing and Treatment standards.**

63. Contracts Manager: Need more detail on specific job duties and functions to be able to write a job description. Only information given is "coordinate UM with DMA".

    - **There are numerous references available for the role of contract manager which may include State Personnel positions, Managed Care Industry descriptions, etc. It is premature to develop job descriptions until the selection process is complete.**

64. What will you use to measure Care Management cultural competency? Training, how much?

    - **See Question #59 above.**

65. Special Team Reviews: How often do these occur per LME catchment area? How are these conducted-Team goes to provider office, review of chart from LME location?

    - **DMA has not requested the UR Vendor to complete a Special Team Review in the past year. The methods for the process employed will be dictated by the individual client needs and specialists utilized. Typically, such reviews would include record review, interviews, observations and recommendations for clinical intervention and plan development.**

66. Will we be provided with all the report files required to perform this function? I do not see all the files referred to in the Attachments.

    - **Report examples and requirements are in the Requirements Document.**

67. What has been the process for negotiating with VO? What are the timeframes that you expect the amendment to be signed?

    - **Negotiations are ongoing entailing meetings, documents, etc. that culminates in a formal contract amendment. These documents must go through numerous reviews within DHHS and the Attorney General's office prior to signature – the timeframe for completion is variable. The LME may include in their proposal anything they see as a condition for this**

process that would affect their ability to implement. Any condition that is not in the revised amendment or expectation of VO will not be required by the LMEs.

68. Why can't the LMEs merge?

- **The legislation enacted this past summer gives Mecklenburg/Guilford/Smokey authority to consolidate administrative functions. The fact that it made specific allowances for these 3 LMEs has led the Attorney General's Office to interpret that other LMEs may not merge. Although this does not appear to have been the intent by the legislature, the law must be applied as interpreted by the legal authorities. Please note the specific legislated language below:**

  SECTION 10.15.(aa) The Secretary of the Department of Health and Human Services shall not take any action prior to January 1, 2010, that would result in the merger or consolidation of LMEs operating on January 1, 2008, or that would establish consortia or regional arrangements for the same purpose, except that: (1) LMEs that do not meet the catchment area requirements of G.S. 122C-115 as of January 1, 2008, may initiate, continue, or implement the LMEs' merger or consolidation plans to overcome noncompliance with G.S. 122C-115, and (2) The Guilford Center for Behavioral Health and Disability Services, the Smoky Mountain Center, and the Mecklenburg County Area Mental Health, Developmental Disability and Substance Abuse Authority may continue with or implement the proposed administrative service organization under development as of March 1, 2008 consolidation of any combination of these entities.

69. If the county MH program LME and guardianship is with DSS (another dept.) who is the legal entity?

- **Rosalind Pettiford from the Division of Aging Guardianship answered that the person in the director or assistant director position of the Human Services agency would be the legal entity. See question # 2 above.**

70. In the costs allocation proposal we had planned to include IPRS in the total UR organization. Do we need to include IPRS?

- **You may include this in your presentation but Medicaid can only pay for Medicaid UR and therefore a separation of costs is essential. Please refer to questions #15, #25-28 above. No cost associated with IPRS operations may be allocated to ANY Medicaid funding.**

71. Does VO have staff after 6:00 for inpatient services?

- **No. VO is manned 8am to 6pm Monday – Friday. The specifications identify a response time of 4 hours for initial requests which is applied to available business hours. Hospitals are required to continue to submit requests both via phone and fax during weekends and holidays. These must be responded within the 4 hour time period on the following business day.**

72. What is the process for contract negotiations? Should the LME consider legal costs with this analysis? Any estimate of the number of times in the past year or so that legal has had to deal with contract issues?

- **Attorneys only get involved at a point of contract amendment or disputes. In the past year the attorneys have probably been involved on the maybe 3-4 times regarding contract issues. There have been other vendor activities that have required legal involvement but that was used at the discretion of the vendor and not due to legal involvement by DMA. Changes to day to day operations are done outside of the contract process either in writing or email.**

73. Are erroneous decisions on page 62 a current requirement of VO?

- **Erroneous decisions are defined as errors in following policy or service requirements in authorizations. This is not related to the clinical judgments applied in authorizations. The only current penalty in the VO contract that has resulted in payment reductions is for CONs. As noted in Question # 6 above, the first effort is toward quality improvement and penalties are applied following a period of continued performance problems.**

74. Has VO paid any penalties on CON?

- **Yes, as identified in post payment reviews. To date, there has been approximately $250,000 disputed.**

75. If an LME is currently using algorithms do you want them in the proposal even if other LMEs may not be using them?

- **Yes. Once chosen, DMA/DMH along with VO and the selected LMEs will work together and adopt the algorithms and processes which will be used statewide.**

76. How will transition and end dating take place?

- **Once the LMEs are chosen, DMA/DMH, VO and selected LMEs will work together on the transition plan and end dating authorizations, etc.**

77. Since it is near the Holidays, will there be an additional chance to ask questions?

- **No, it is not our intent to offer additional Question & Answer sessions. Further, we can not respond to any additional LME specific inquiries as that may provide the appearance of an unfair advantage.**

78. The requirements state overlapping dates for PA is not allowed. Is this just for the same service?

- **Yes. It is allowed for different services.**

79. Does pass thru count against the LME?

- **DMA is in the process of getting all those services directly enrolled. In the meantime since this is just a funding pass-through and not a divesture issue, it is allowed. See question #35 above.**

80. Currently for SA UM authorizations this information is de identified. Will this information now be available?

- **Yes for the population you are responsible for since the LMEs selected will be a vendor, this information will be available. Paid claims data is not related to UR/UM functions.**

81. Is it allowable to contract with another provider to bill for that provider? (Third party administration)

- **Yes. The LME is the billing agency for a provider and that function may be subcontracted. This has nothing to do with the UR process**.

82. On # 24 on the checklist, do you want the LME to make something up?

- **We are looking for the LME's projections of what this process may entail with timelines. This will provide insight into your degree of knowledge about the UR process and operations.**

LME UM SESSION ATTENDANCE SHEET

NAME	AGENCY
Michelle Wilder	DHHS Guardianship
Donald Graves	CMS
Martha Joslin	Mecklenburg LME
Vivian Harris	Durham LME
Sarah Grey	Durham LME
Susan Hanson	Southeastern Center LME
Dan Jones	Onslow-Carteret LME
Susan Taggart	Onslow-Carteret LME
Maria Ballard	Pathways LME
Rhett Melton	Pathways LME
Randy Edwards	Pathways LME
Bob Canupp	Eastpointe LME
Ken Jones	Eastpointe LME
Tom Miller	Eastpointe LME
Christal Wood	Eastpointe LME
David Swann	Crossroads LME
Wanda Piland	East Carolina LME
Cham Trowell	East Carolina LME
Don Herring	Western Highlands LME
Joy Futrell	East Carolina LME
Cindy Ehlers	East Carolina LME
Gail Hinson	Crossroads LME
Mike Piombino	DMA/DIRM
David Coffman	EDS
Debbie Pittard	DMA
Gina Rutherford	DMA
Julie Sinclair	DMH/DD/SAS
Peter Bernardini	DMA
Jay Coughenour	Strategic Behavioral Health
Jim Shaheen	Strategic Behavioral Health
Debra Farrington	Orange-Person-Chatham LME
Flo Stein	DMH/DD/SAS
Ann Wood	Wake LME
Larry Fuller	Wake LME
Catharine Goldsmith	DMA
Christina Carter	DMH/DD/SAS
Eric Johnson	DMH/DD/SAS
Vincent Stephens	CMS
Grayce Crockett	Mecklenburg LME
Bonnie Hill	Association for Retarded Citizens
Barbara Docimo	Association for Retarded Citizens

Carlos Hernandez	Mecklenburg LME
Rosalyn Pattyford	DAAS